***FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

**(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)**

State/Territory: Georgia
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: March 31, 2000

Reporting Period: October 1, 1998 through September 30, 1999

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## SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The estimated baseline number of low-income children without creditable coverage in the State of Georgia is 267,125. This is a revised baseline estimate from the original 227,603 reported in the state plan (See Table 1). Of this number, 147,567 could be eligible for the existing Medicaid program, and the other 119,558 are potentially eligible for Georgia CHIP (PeachCare for Kids). The estimate of potentially eligible Medicaid and PeachCare for Kids recipients is based solely on age and income. No other criteria can be specified in the CPS analysis. For example, State employees and individuals leaving welfare are included in these numbers even though there are limits on their eligibility for public insurance.

This estimate is different from the estimated number of PeachCare eligibles (102,982) submitted in the state plan. The 1998 report was based on estimates from Current Population Survey (CPS) combined 1995, 1996, and 1997 data. Our new estimate is based upon updated CPS data.

Table 1

| ***Uninsured Medicaid eligible and PeachCare eligible Children in Georgia*** | | | |
|---|---|---|---|
| *Attributes of Population* | *Total Uninsured Children* | *Low-Income Children without Creditable Coverage* | |
| | | Eligible for Medicaid | Eligible for PeachCare for Kids |
| **Total** | 376,769[1] | 147,567 (39%) | 119,558 (32%) |
| **Income Level** | | | |
| Less than 100% | 128,961 (34%) | 128,961 (87%) | 0 |
| 100-133% | 46,461 (12%) | 10,177 (7%) | 36,284 (30%) |
| 134-185% | 76,189 (20%) | 8,429 (6%) | 67,760 (57%) |
| 186-200% | 15,514 (4%) | 0 | 15,514 (13%) |
| Greater than 200% | 109,644 (29%) | 0 | 0 |
| **Age** | | | |
| 0 to 1 | 23,104 (6%) | 14,807 (10%) | 1,843 (2%) |
| 1-5 | 91,489 (24%) | 28,968 (20%) | 29,933 (25%) |
| 6-12 | 119,874 (32%) | 38,095 (26%) | 53,676 (46%) |
| 13-18 | 142,302 (38%) | 65,697 (46%) | 34,106 (29%) |
| **Race/Ethnicity** | | | |
| Black, non-Hispanic | 157,054 (42%) | 88,277 (60%) | 37,705 (32%) |
| Hispanic | 26,584 (7%) | 15,929 (11%) | 6,111 (5%) |
| White, non-Hispanic | 180,047 (48%) | 36,948 (25%) | 74,646 (62%) |
| Other[2] | 13,086 (3%) | 6,415 (4%) | 1,096 (1%) |
| **Location** | | | |
| MSA/Urban | 220,936 (59%) | 86,223 (58%) | 57,918 (48%) |
| Non-MSA/Rural | 155,834 (41%) | 61,345 (42%) | 61,640 (52%) |

SOURCE: Current Population Survey, combined 1997, 1998, 1999 data as calculated by William Custer and Pat Ketsche, Georgia State University. Table compiled by Georgia Health Policy Center, 02/10/2000
Revised 02/28/2000

[1] Uninsured children whose family exceeds 200% FPL are included in the total number of uninsured (shown in column 1).
[2] Sample size is very small and numbers should be used with caution.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The source of the data is the Current Population Survey, combined from 1997, 1998, and 1999 (data for years 1996, 1997, and 1998) as calculated by William S. Custer, Ph.D. and Patricia Ketsche, Center for Risk Management and Insurance Research, Georgia State University.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The number of Georgia respondents is small (n = 1,500) compared to the state population, making the confidence intervals on these estimates very large. Also, the Current Population Survey consistently underreports the number of individuals on Medicaid compared to State Medicaid reports.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

In FY 1999, there were 47,584 children enrolled in PeachCare for Kids, which is 40 percent of the estimated 119,558 of eligible children in Georgia.

1.2.1 What are the data source(s) and methodology used to make this estimate?

The data sources used are the Current Population Surveys (combined data from 1997, 1998, and 1999) and the HCFA Quarterly Report (FFY 1999).

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Since HCFA quarterly reports are based on actual numbers, the State of Georgia assesses that its enrollment numbers are 100% accurate. The reliability of the CPS data is addressed in Question 1.1.2.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

***Table 1.3***

| (1) Strategic Objectives (as specified in Title XXI State Plan) | (2) Performance Goals for each Strategic Objective | (3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN** | | |
| Increase insurance coverage among Georgia's low-income children. | By the end of the *second year*, enroll 60% of uninsured, non-Medicaid eligible children with family income below 200% FPL (approx. 60,000). | Data Sources: Enrollment data<br><br>Methodology: Frequency calculation<br><br>Numerator: Number of children enrolled in PeachCare for Kids FY 1999 - 47,584 children<br><br>Denominator: Number of uninsured, non-Medicaid eligible children below 200% FPL - 119,558<br><br>Progress Summary: By the end of the first fiscal year, 47,584 children enrolled in PeachCare for Kids. As of March 1, 2000 - 70,127 children (59%) have enrolled. |
| **OBJECTIVES RELATED TO CHIP ENROLLMENT** | | |
| Increase insurance coverage of Georgia's low-income children. | Employ marketing and outreach techniques that encourage parents of eligible, low-income children to enroll their children in Georgia CHIP. | Data Sources: New enrollee survey<br><br>Methodology: 1,756 new enrollees surveyed<br><br>Numerator: Number of respondents stating they heard of PeachCare through marketing techniques (advertisements and outreach)<br><br>Progress Summary: 41% of survey respondents reported they heard about PeachCare through advertisements, while 15% stated that they heard about the program through outreach. |
| **OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)** | | |
| Increase the percentage of low-income children with a regular source of care. | Over time, decrease the percent of children matched to a PCP through auto assignment. | Data Sources: Enrollment data<br><br>Methodology: Frequency calculation<br><br>Numerator: Number of children matched to a PCP through auto assignment<br><br>Progress Summary: 41,713 children (70.9%) chose their own PCP on enrollment. (Through November 30, 1999). Not enough time has lapsed to measure a change in auto assignment. |

| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)** | | |
| Increase the percentage of low-income children with a regular source of care. | Encourage use of PCP through health plan policies and education. | Data Sources: Claims Data<br><br>Methodology: Frequency calculation<br><br>Numerator: Number of children who see the same provider for at least 75% of their visits<br><br>Denominator: Children who have been continuously enrolled one year<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Increase the percentage of low-income children with a regular source of care. | Maximize the number of enrollees who stay with their PCP for 12 months. | Data Sources: Claims Data<br><br>Methodology: Frequency calculation<br><br>Numerator: Number of children who stay with their PCP for 12 months<br><br>Denominator: Children who have been continuously enrolled one year<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| **OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)** | | |
| Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and Georgia Better Health Care. (These are 80% for screening.) | Assess how many children receive recommended well-visits and screenings. | Data Sources: Claims data<br><br>Methodology: Frequency calculation<br><br>Numerator: Number of enrolled children receiving well-visits and screenings<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and Georgia Better Health Care. (These are 90% for immunizations.) | Assess how many children receive immunizations. | Data Sources: Claims data<br><br>Methodology: Frequency calculation<br><br>Numerator: Number of enrolled children receiving immunizations<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |

| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)** | | |
| Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and Georgia Better Health Care. (These are 80% for screening and 90% for immunizations.) | Increase provider and patient compliance with use of primary and preventive services by feeding back information to providers and health plans about their rates of screening for the enrolled population. | Data Sources: Paid claims from 10/01/98 - 09/23/99<br><br>Methodology: Longitudinal data analysis<br><br>Numerator: Number of enrolled children receiving immunizations<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| **OTHER OBJECTIVES (SPECIFY)** | | |
| Decrease unnecessary use of emergency departments for non-emergency services. A non-emergency service is one that does not meet the prudent layperson definition of emergency. | Reduce the number of ED visits for non-emergency services. | Data Sources: Claims Data<br><br>Methodology: Longitudinal data analysis<br><br>Numerator: Number of non-emergency ED visits<br><br>Denominator: Enrolled population<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Decrease unnecessary use of emergency departments for non-emergency services. | Reduce the number of ED visits for non-emergency services. | Data Sources: Claims Data<br><br>Methodology: Longitudinal data analysis<br><br>Numerator: Number of children with repeat ED visits<br><br>Denominator: Number of children with ED visits<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Decrease unnecessary use of emergency departments for non-emergency services. | Identify providers with a high rate of referrals to the emergency department and provide data on ED utilization. | Data Sources: Claims Data<br><br>Methodology: Cross-sectional data analysis<br><br>Numerator: Number of ED visits<br><br>Denominator: Patients of doctors with high referral rates<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |

| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OTHER OBJECTIVES (SPECIFY)** | | |
| Decrease unnecessary use of emergency departments for non-emergency services. | Examine the rate of authorized referrals by provider to assess whether or not patients are gaining access to primary care. | Data Sources: Claims Data<br><br>Methodology: Cross-sectional data analysis<br><br>Numerator: Number of ED referrals by providers who received letters before and after intervention<br><br>Denominator: Patients served by PCPs who received letters<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Decrease unnecessary use of emergency departments for non-emergency services. | Examine the rate of authorized referrals by provider to assess whether or not patients are gaining access to primary care. | Data Sources: Claims Data<br><br>Methodology: Cross-sectional data analysis<br><br>Numerator: Number of ED visits for the same condition<br><br>Denominator: All children with an ED visit<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Reduce preventable hospitalizations. | Reduce preventable hospitalizations in the second year of the program. | Data Sources: Claims Data<br><br>Methodology: Cross sectional data analysis<br><br>Numerator: Number of preventable hospitalizations based on an existing screening methodology<br><br>Denominator: Enrolled children<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |

| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OTHER OBJECTIVES (SPECIFY)** | | |
| Reduce preventable hospitalizations. | Provide data to providers on preventable hospitalizations among patient panel to encourage improvement in care management. | Data Sources: Claims Data<br><br>Methodology: Longitudinal analysis<br><br>Numerator: Preventable hospitalizations per PCP in year one<br><br>Denominator: Preventable hospitalizations per PCP in year two<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health). | Assess the number of children whose asthma is managed through appropriate outpatient care. | Data Sources: Claims Data<br><br>Methodology: Cross sectional data analysis<br><br>Numerator: Number of children seeing PCP within two weeks of ER or hospital visit<br><br>Denominator: Number of children receiving care from hospital/ED for asthma<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health). | Assess the number of children whose asthma is managed through appropriate outpatient care. | Data Sources: Claims Data<br><br>Methodology: Cross sectional data analysis<br><br>Numerator: Number of children receiving drug regimen consistent with national guidelines<br><br>Denominator: Number of children with asthma<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |

| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OTHER OBJECTIVES (SPECIFY)** | | |
| Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health). | Assess the number of children whose asthma is managed through appropriate outpatient care. | Data Sources: Claims Data<br><br>Methodology: Cross sectional data analysis<br><br>Numerator: Number of children for whom appropriate asthma management tools (such as nebulizers, spacer, and mattress bags, etc.) are prescribed<br><br>Denominator: Number of children with asthma<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health). | Assess the number of children whose asthma is managed through appropriate outpatient care. | Data Sources: Claims Data<br><br>Methodology: Cross sectional data analysis<br><br>Numerator: Number of children and parents receiving education on asthma<br><br>Denominator: Parents of a child with asthma<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |
| Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health). | Assess the number of children whose asthma is managed through appropriate outpatient care. | Data Sources: Survey of asthma patient's parents<br><br>Methodology: Phone survey<br><br>Numerator: Summation of parents responding to a survey who say they are reasonably confident they know how to care for their child with asthma<br><br>Denominator: Parents of a child with asthma<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |

| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
|---|---|---|
| **OTHER OBJECTIVES (SPECIFY)** | | |
| Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health). | Provide data to PCPs and health plans about performance on asthma care measures so that practices can be modified and appropriate educational materials for patients developed. | Data Sources: Claims Data<br><br>Methodology: Cross sectional data analysis<br><br>Numerator: Summation of PCPs whose performance on above indicators improves in subsequent years<br><br>Progress Summary: Not enough time has lapsed to measure this goal. |

**Objective 1:** Increase insurance coverage among Georgia's low-income children.

**Performance Goals**

1. By the end of the second year, enroll 60% (approximately 60,000) of uninsured, non-Medicaid eligible children with family incomes below 200% FPL.
2. Employ marketing and outreach techniques that encourage parents of eligible, low-income children to enroll their children in Georgia CHIP.

**Performance to Date**

PeachCare for Kids has exceeded our goals. By the end of our ***first*** year (FFY 1999), we had 47,584 enrollees. As of March 1, 2000 --- 70,127 children were enrolled in PeachCare for Kids.

Based on a survey sent to a random sample of 500 new families each month, 41 percent of respondents reported that they heard about PeachCare for Kids through advertisements, while 15 percent indicated that they heard about the program through outreach. Thirty-six percent of new enrollees indicated that they heard about PeachCare through friends, family members, and church, while others heard about it through their health care provider (23%), the public health department (14%), and school (10%). On average, the survey had a 44% response rate.

In addition, we have awarded twenty-five mini-grants to community-based organizations for innovations in local outreach. Results of this effort will be available in August 2000.

**Barriers to Meeting Goals & Future Plans Regarding Process**

Through our new enrollee surveys, we learned what motivated our enrollees to apply. Though we have exceeded our enrollment goal thusfar, there are areas where we can do more. The responses and suggestions from our focus groups of eligible non-participants indicated how we should refine our marketing and outreach techniques to reach other eligible non-participants.

Issues of trust, cultural variances, immigration status, language differences, and illiteracy are often barriers and reasons that traditional approaches do not reach our non-participating families. Also, families can mistakenly believe they make too much money to qualify. We have already begun to take those suggestions into consideration to incorporate these issues into our marketing materials and outreach efforts. Additional data may be available September 2000.

**Objective 2:** Increase the percentage of low-income children with a regular source of care.

**Performance Goals**

1. Over time, decrease the percent of children matched to a PCP through auto assignment.
2. Encourage use of PCP through health plan policies and education.
3. Maximize the number of enrollees who stay with their PCP for 12 months.

**Performance to Date**

As of November 30, 1999, there were 17,120 children who were matched to a PCP through auto assignment, and 41,713 who chose their own PCP.

**Barriers to Meeting Goals & Future Plans Regarding Process**

Since this is the first full year of the program's inception, not enough time has lapsed to measure the decrease of children matched through auto assignment, and the enrollees who stayed with their PCP for 12 months. We will evaluate how many children stay with their auto assignment PCP, and switch PCPs over the course of a year. In the future, we will increase education in how to utilize a PCP. We will have analyzed a full year of claims data and prepared an updated report by September 2000.

**Objective 3:** Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Finance Administration and Georgia Better Health Care. (These are 80% for screening.)

**Performance Goals**

1. Assess how many children receive recommended well visits and screenings.
2. Assess how many children receive immunizations.
3. Increase provider and patient compliance with use of primary and preventive services by giving feedback information to providers and health plans about their rates of screening for the enrolled population.

**Performance to Date**

Claims data as of September 30, 1999 indicate over 2,377 children had well visits and screenings, and 4,106 children received immunizations. Within the first thirty days of eligibility, 904 children had well visits and screenings, and 1,686 children received immunizations. There were over 29,000 children who had claims filed with PeachCare for Kids, and of those 16,440 were filed for dates of service within the first thirty days of eligibility. Additional age-adjusted data will be available in September 2000.

**Barriers to Meeting Goals & Future Plans Regarding Process**

It is too soon to compare specific timing of screenings/immunizations to the child's age to know whether utilization corresponds to AAP guidelines. Over the course of this year and the next, we will evaluate use compared to guidelines, and then the percentage of PCP panels with improved screening rates. Additional data will be available in September 2000.

**Objective 4:** Decrease unnecessary use of emergency departments for non-emergency services.

**Performance Goals**

1. Reduce the number of ED visits for non-emergency services.
2. Identify providers with a high rate of referral to the emergency department and provide data on ED utilization.
3. Examine the rate of authorized referrals by provider to assess whether or not patients are gaining access to primary care.

**Performance to Date**

Too soon to measure decrease in utilization.

**Barriers to Meeting Goals & Future Plans Regarding Process**

Since we need a full year to measure trends, not enough time has lapsed in order to measure the decrease of non-emergency services. Additional data will be available June 2001.

**Objective 5**: Reduce preventable hospitalizations.

**Performance Goals**

1. Reduce preventable hospitalizations in the second year of the program.
2. Provide data to providers on preventable hospitalizations among patient panel to encourage improvement in care management.

**Performance to Date**

Too soon to measure reduction in preventable hospitalizations.

**Barriers to Meeting Goals & Future Plans Regarding Process**

Not enough time has lapsed in order to measure the reduction of preventable hospitalizations. By September 2000, we will have analyzed preventable hospitalizations in the first year. By June 2001, we will have analyzed two year trends.

**Objective 6:** Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart, Lung and Blood Institute of the National Institutes of Health).

**Performance Goals**

1. Assess the number of children whose asthma is managed through appropriate outpatient care.
2. Provide data to PCPs and health plans about performance on asthma care measures so that practices may be modified and educational materials for patients appropriately developed.

**Performance to Date**

Too soon to measure the number of children whose asthma is managed through outpatient care.

**Barriers to Meeting Goals & Future Plans Regarding Process**

We will look at the percentage of children: seeing PCPs within 2 weeks of ED/hospital visits; receiving drug regimens consistent with national guidelines; and receiving appropriate asthma management tools (i.e., nebulizers, spacers, mattress bags, etc.) as prescribed. We will also look at the percentage of parents who receive education/educational materials, and parents responding to a survey who say they are reasonably confident that they know how to care for their child with asthma. In the future, we will provide data to PCPs and health plans about performance on asthma care measures so that appropriate educational materials for patients may be developed. We will measure the percentage of PCPs whose performance on above indicators improves in subsequent years. Data on asthma care in year one will be available by September 2000. Data comparing two year trends will be available by June 2001.

## SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

✓ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: PeachCare for Kids

Date enrollment began (i.e., when children first became eligible to receive services): Pilot Program - 11/01/98, Statewide - 01/01/99

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. N/A

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. N/A

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

**Medicaid:** Medicaid continues to provide health care to newborns, infants and adolescents from birth through age 19. Eligibility is based on income. The maximum income by age is:

| | |
|---|---|
| Pregnant women and their newborn children | 200% FPL |
| Infants up to age 1 | 185% FPL |
| Children ages 1 through 5 | 133% FPL |
| Children ages 6 through 19 | 100% FPL |

PeachCare for Kids is a part of the Georgia Department of Community Health, Division of Medical Assistance – the State agency responsible for the Medicaid program. While the two programs have separate enrollment and eligibility determination processes, PeachCare for Kids uses the Medicaid delivery system for the provision of medical care. In passing CHIP legislation, the Georgia General Assembly sought to take advantage of Medicaid's strengths (i.e., its purchasing power and broad provider network), while still allowing a separate state plan.

PeachCare for Kids covers children up to 200% FPL who do not qualify for Medicaid. PeachCare and Medicaid use the same income calculations, including

disregards for working adults to ensure that Medicaid-eligible children are enrolled in that program.

**Healthy Kids Replication Program Grant:** The Georgia Health Policy Center at Georgia State University was the recipient of a planning grant from the Healthy Kids Replication Program, a national program of the Robert Wood Johnson Foundation and the Florida Healthy Kids Corporation. The funding and technical assistance that were provided through this grant assisted Georgia in designing and pricing a children's health insurance program. Funding ended when Congress passed CHIP.

**Georgia Partnership for Caring Foundation:** The Georgia Partnership for Caring Foundation (GPCF) was established in 1994 and represents a unique partnership between state government and the private sector. The mission of GPCF is to establish a free health care referral program for Georgians who cannot afford private health insurance but are not eligible for governmental medical assistance such as Medicaid or Medicare. Funding has been provided by grants from individuals, associations, and the Departments of Human Resources and Community Health.

The program includes the limited voluntary services of physicians, nurse practitioners, dentists, ophthalmologists, optometrists, physician's assistants, hospitals, pharmacists, pharmaceutical manufacturers, and many health provider groups and agencies. These volunteers are not paid for their services or products, but are committed to assisting Georgians obtain access to needed health care coverage. The program is available in about three-fifths of Georgia's counties. GPCF is not insurance coverage. It is for emergencies or urgent care situations. Application processing time averages 1 month. Right from the Start Medicaid (RSM) outreach workers are involved in the referral and application process for GPCF. They perform the screening function to determine that individuals who are referred to GPCF are not eligible for Medicaid.

Since PeachCare for Kids began, GPCF has been able to serve as a referral source for PeachCare. It has altered its eligibility criteria to exclude PeachCare eligible children.

**Caring Program:** The goal of the Caring Program for Children was to provide primary and preventive health care coverage to underprivileged children of working Georgians at no cost to their parents or guardians. To participate in this program, children must not have been eligible for Medicaid or any private health insurance plans. Benefits of the plan included preventive care, emergency medical care, and prescription drugs. RSM outreach workers referred children found to be ineligible for Medicaid to this program. Funding for the program

came from contributions from businesses, corporations, religious organization, foundations, health care professionals, civic organizations and individuals with matching funds provided by Blue Cross and Blue Shield of Georgia. The Caring Program was not a regulated insurance product and did not offer "creditable coverage."

The Caring Program was discontinued in April 1999 with the implementation of PeachCare for Kids. Between January and April, the Caring Program and PeachCare worked closely together to assist families in applying for PeachCare for Kids and transitioning from one program to another.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

✓ No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" (Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?)

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

✓ Changes to the Medicaid program

- ___ Presumptive eligibility for children
- ✓ Coverage of Supplemental Security Income (SSI) children
- ___ Provision of continuous coverage (specify number of months ___)
- ___ Elimination of assets tests
- ✓ Elimination of face-to-face eligibility interviews
- ✓ Easing of documentation requirements

Medicaid enrollment increased 1.2% between 1996 (622,336) and 1999 (629,529). On November 1, 1998, the state implemented an expansion of eligibility from 185% up to 200% FPL for pregnant women and their infants.

✓ Impact of welfare reform on Medicaid enrollment & changes to AFDC/TANF (specify) _____

There is a study being conducted at Georgia State University, which examines the link between welfare reform and the decrease in Medicaid enrollment; however, this study is still in progress. Though we cannot currently link welfare reform changes to Medicaid enrollment, there are some notable observations. We do know that the number of AFDC recipients declined from FY 1997 to 1998 (See Table 2). In FY 1998, there were approximately 30,000 fewer AFDC recipients of cash assistance. In 1998, there were 3,552 more (Children and Adults in Families with Dependent Children) *not* receiving cash assistance than in 1997 (See Table 3).

| Table 2 | 1997 | 1998 |
|---|---|---|
| *Categorically Needy Receiving Cash Assistance* | *Recipients* | *Recipients* |
| Children in Families w/Dependent Children | 213,719 | 165,136 |
| Adults in Families w/Dependent Children | 89,493 | 59,874 |
| Total | 303,212 | 225,010 |

| Table 3 | 1997 | 1998 |
|---|---|---|
| *Categorically Needy **Not** Receiving Cash Assistance* | *Recipients* | *Recipients* |
| Children in Families w/Dependent Children | 111,436 | 113,164 |
| Adults in Families w/Dependent Children | 48,305 | 50,129 |
| Total | 159,741 | 163,293 |

✓ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- ✓ Health insurance premium rate increases
- ✓ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

According to a regional survey of average health care cost changes conducted by Hewitt Associates, average health care premiums purchased through employers increased by 3.7% nationally in 1998. In Georgia, Hewitt reported that from 1997 to 1998, there was a 3.8% increase in average health care costs. As health care premiums increase, coverage is likely to decrease.

There were no major changes to state insurance regulations last year. Though the Georgia legislature has passed some new mandates, we estimate that only 5-25% of Georgians are in health plans affected by mandates. We expect the impact of mandates on price or access to

insurance to be negligible.[1] We know of no other changes in the private health insurance market, which would affect the accessibility and affordability of healthcare for children.

✓ Changes in the delivery system

___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

✓ Changes in hospital marketplace (e.g., closure, conversion, merger)

___ Other (specify) _____

Egleston Children's Healthcare System and Scottish Rite Children's Medical Center merged to form Children's Healthcare of Atlanta, one of the largest providers of pediatric healthcare in the country. Aetna, Prudential, U.S. Healthcare, and NYLCare merged to form the nation's largest HMO in the nation. Though some of the largest healthcare mergers in the nation have occurred in Georgia, a decrease in services offered to children is not expected. Currently there is no evidence to suggest that these mergers affect those eligible for PeachCare or Medicaid.

___ Development of new healthcare programs or services for targeted low-income children (specify) _____

✓ Changes in the demographic or socioeconomic context

✓ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____

✓ Changes in economic circumstances, such as unemployment rate (specify) unemployment rate

___ Other (specify)_____

According to a report by *The Augusta Chronicle*, Hispanics and Asians are among the fastest growing populations in the State of Georgia.[2] Georgia's Hispanic population rose from 110,041 in 1990 to 220,312 in 1998, while the Asian population increased from 77,994 in 1990 to 149,451 in 1998. U.S. Census Bureau data shows that while Georgia's population increased 17.5 percent since 1990, the number of Hispanics and Asians rose 100.2 percent and 91.6 percent, respectively. [3]

According to the report, immigrants are attracted to Georgia because of its diversified economy, good job market and competitive salaries. During this time, Georgia Economic Indicators show that the unemployment rate

[1] Snyder, Susan R. and Carey M. O'Connor, *Health Insurance Mandates: Cost and Effects*, Issue Brief, Georgia Health Policy Center, School of Policy Studies, Georgia State University, November 1999.
[2] Joyner, Amy. (1997, December 28), Immigrant Populations Growing Fast, *The Augusta Chronicle Online*, [www.augustachronicle.com], November 30, 1999.
[3] Bixler, Mark, "Asians, Latinos Making Mark in Area", *The Atlanta Journal-Constitution*, September 15, 1999.

dropped from 4.7 to 3.9 percent.[4] *The Associated Press* asserts that one of the reasons for this is because immigrants have taken lower wage jobs.[5]

These changes affect PeachCare for Kids. Based on what we already know about insurance accessibility, we can assume that those in lower wage jobs will not be able to afford health insurance, even when employers offer it. There is a need to understand the barriers to access and enrollment, specifically for Hispanics. Based on what we learned from focus groups of unenrolled, eligible families, we have attempted to understand and break through these barriers, which include improving our materials marketing techniques (i.e., presenting English and Spanish marketing materials) and increasing community outreach.

[4] *Georgia Economic Indicators*, Historical Series 1985-1998, Georgia Department of Labor, Volume 5, 1998.
[5] Pilcher, James, "Hispanics fill Georgia Labor Void", *Associated Press*, September 14, 1999.

## SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

***Table 3.1.1***

| | **Medicaid CHIP Expansion Program** | **State-designed CHIP Program** | **Other CHIP Program*** _____ |
|---|---|---|---|
| Geographic area served by the plan (Section 2108(b)(1)(B)(iv)) | N/A | Statewide | N/A |
| Age | | 0 through 18 | |
| Income (define countable income) | | Above Medicaid, and up to 200%FPL. Gross income of legally-responsible adults in the household, including wages from employment, Social Security Income, SSI, worker's compensation, pension or retirement benefits, child support, unemployment benefits, and contributions. Disregards are applied as follows: $90 of each legally-responsible working adult in the household, $50 of child support, and up to $200 for daycare for a child under two or up to $175 for someone over the age of two. | |
| Resources (including any standards relating to spend downs and disposition of resources) | | N/A | |
| Residency requirements | | Must be Georgia resident. | |
| Disability status | | N/A | |
| Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i)) | | Must be uninsured at time of application; must not have access to state-sponsored health benefits. | |
| Other standards (identify and describe) | | Must not have voluntarily dropped coverage 3 months prior to coverage under PeachCare. | |

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.2 How often is eligibility redetermined?

| ***Table 3.1.2*** | | | |
|---|---|---|---|
| **Redetermination** | **Medicaid CHIP Expansion Program** | **State-designed CHIP Program** | **Other CHIP Program*** _____ |
| Monthly | | | |
| Every six months | | | |
| Every twelve months | | ✓ | |
| Other (specify) | | Families are required to report changes in income, family composition, or health coverage status within 10 days of such change. | |

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes Which program(s)? _____
For how long? _____

✓ No

3.1.4 Does the CHIP program provide retroactive eligibility?

___ Yes Which program(s)? _____
How many months look-back? _____

✓ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes Which program(s)? _____
Which populations? _____
Who determines? _____

✓ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

✓ Yes Is the joint application used to determine eligibility for other State programs? If yes, specify

___ No

The PeachCare for Kids application serves as a Medicaid application for children who are identified as potentially eligible for coverage under Medicaid through the PeachCare for Kids application process. Families may also apply for Medicaid for themselves and their children through the Department of Family and Children Services.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children.

The PeachCare for Kids application is a single page mail-in application, available in English and Spanish, which parents can request by calling a toll-free number. Applications are also available throughout communities in schools, hospitals, physician offices, libraries and churches. The PeachCare application asks for all the information that is necessary for an eligibility determination. Validation of the information is based on self-declaration by the families. The process to determine eligibility is the responsibility of the State and not the parents. It does not require additional documentation that may be cumbersome to families and create barriers to the application process. At this time, applications are entered into the system within 48 hours of receipt. The third party administrator must perform eligibility determination within 10 days to meet contract performance specifications. Coverage always begins on the first day of the following month.

Applications of children identified as potentially eligible for Medicaid are referred to Medicaid eligibility staff for review – without requiring intervention of the parents. Parents are given the opportunity to request to have the application referred to Medicaid, if the children are identified as potentially eligible, by checking a box on the application. This helps parents understand that if they do not qualify for PeachCare, they have already opted for Medicaid without requiring an additional application. For families who do not elect to enroll their children in Medicaid (if eligible), a representative from Right from the Start Medicaid (RSM) calls the parents and provides counseling, informing the parents of the benefits of the program. While no parent has ultimately refused Medicaid after speaking with an RSM worker, this is a tremendous strength to the program as families receive the information necessary for them to make an informed choice and correct any misperceptions they may have about the Medicaid program.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The redetermination process was designed to facilitate the retention of eligible children in PeachCare for Kids. Shortly before a child's anniversary date, the parent is sent a letter with the children's account information. Parents are asked to call the toll-free number only to report changes. If there are no changes, parents need only continue paying the premium, if required. Parents are reminded that should there be any changes to the listed information, they must be reported within 10 days of such change. Like the initial application, the process relies on self-declaration and does not require additional documentation from the families. The strength of this approach is that it applies the ease and simplicity of the application process to the redetermination process.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any). Benefits limits are the same as those imposed on the Medicaid program.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

| ***Table 3.2.1 CHIP Program Type*** State-designed CHIP Program | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (✓ = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Inpatient hospital services | ✓ | None | Services are covered in full. |
| Emergency hospital services | ✓ | None | Services are covered in full. |
| Outpatient hospital services | ✓ | None | Services are covered in full. |
| Physician services | ✓ | None | Services are covered in full. Prior approval is needed for some procedures. |
| Clinic services | ✓ | None | Services are covered in full. |
| Prescription drugs | ✓ | None | Some drugs require prior approval or have therapy limitations. Limit 6 per month with prior approval. |
| Over-the-counter medications | ✓ | None | Some medications are covered in full |
| Outpatient laboratory and radiology services | ✓ | None | Covered in full for physician ordered services. |
| Prenatal care | ✓ | None | Services are covered in full. |
| Family planning services | ✓ | None | Some services are covered. |
| Inpatient mental health services | ✓ | None | Some services are covered, and some limitations apply. |
| Outpatient mental health services | ✓ | None | Some services are covered, and some limitations apply. |
| Inpatient substance abuse treatment services | ✓ | None | Services are covered only for short-term acute care, and some restrictions apply. |
| Residential substance abuse treatment services | ✓ | None | Services are covered only for short-term acute care, and some restrictions apply. |
| Outpatient substance abuse treatment services | ✓ | None | Some services are covered, and some limitations apply. |
| Durable medical equipment | ✓ | None | Some services are covered, and some restrictions apply. |
| Disposable medical supplies | ✓ | None | Prior approval may be required. |

| ***Table 3.2.1 CHIP Program Type*** PeachCare for Kids | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (✓ = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Preventive dental services | ✓ | None | Some services are covered, and some restrictions apply. |
| Restorative dental services | ✓ | None | Some services are covered, and some restrictions apply. |
| Hearing screening | ✓ | None | Services are covered in full. |
| Hearing aids | ✓ | None | Some services are covered, and some restrictions apply. |
| Vision screening | ✓ | None | Some services are covered. |
| Corrective lenses (including eyeglasses) | ✓ | None | Services including eyeglasses, refractions, dispensing fees, and other refractive services are covered. Some limitations apply. |
| Developmental assessment | | | |
| Immunizations | ✓ | None | Services are covered in full. |
| Well-baby visits | ✓ | None | Some services are covered, and some limitations apply. |
| Well-child visits | ✓ | None | Some services are covered, and some limitations apply |
| Physical therapy | ✓ | None | Some services are covered, and some limitations apply. |
| Speech therapy | ✓ | None | Some services are covered, and some limitations apply. |
| Occupational therapy | ✓ | None | Some services are covered, and some limitations apply. |
| Physical rehabilitation services | | | |
| Podiatric services | ✓ | None | Some services are as authorized within the Georgia statue governing podiatric services. |
| Chiropractic services | | | |
| Medical transportation | ✓ | None | Emergency ambulance services are covered for an enrollee whose life and/or health is in danger. |

| ***Table 3.2.1 CHIP Program Type*** PeachCare for Kids | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (✓ = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Home health services | ✓ | None | Some services are covered. |
| Nursing facility | | | |
| ICF/MR | | | |
| Hospice care | ✓ | None | Covered under a plan of care when provided by an enrolled hospice provider. |
| Private duty nursing | | | |
| Personal care services | | | |
| Habilitative services | | | |
| Case management/Care coordination | | | |
| Non-emergency transportation | | | |
| Interpreter services | | | |
| Other (Specify) Surgical Services | ✓ | None | Services are covered in full. |
| Other (Specify) Nursing care services | ✓ | None | Some services are covered. |
| Other (Specify) End stage renal disease | ✓ | None | Some services are covered. |
| Other (Specify) Physician's Assistant Services | ✓ | None | Some services are covered. |

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

**Inpatient Services**
Inpatient services include all physician, surgical and other services delivered during a hospital stay. Inpatient services are covered in full.

**Outpatient Services**
Outpatient services include outpatient surgery, clinic services and emergency room care. Outpatient services are covered in full.

**Physician Services**
Physician services include most of the services provided by a participating physician for the diagnosis and treatment of an illness or an injury. Physician services are covered in full. Prior approval is needed for some procedures.

**Clinic Services**
Services are covered in full (including health center services).

**Prescription Drugs**
Prescribed drugs and supplies approved by DMA and dispensed by an enrolled pharmacist are covered in full. Some drugs require prior approval or have therapy limitations. Prescriptions or refills are limited to six per month per enrollee without prior approval.

**Over-the-counter medications**
The following medications are covered in full: Multi-vitamins and multi-vitamins with iron, enteric coated aspirin, diphenhydramine, insulin, NIX, iron, meclizine, insulin syringes and urine test strips. No other over-the-counter medications are covered.

**Outpatient Laboratory and Radiology Services**
Covered in full for physician ordered services.

**Prenatal Care**
Services are covered in full. This includes Childbirth Education Services, a series of eight classes regarding the birth experience and tools to prepare for a healthier pregnancy, birth and postpartum period.

**Family Planning Services**
Covered services include initial and annual examinations, follow-up, brief and comprehensive visits.

**Inpatient Mental Health Services**
Inpatient mental health services are covered only for short-term acute care in general acute care hospitals up to 30 days per admission. Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered. Residential or other 24-hour therapeutically planned structural services are covered only through the DHR MATCH Program.

**Outpatient Mental Health Services**
Services are covered through: Community Mental Health Centers, subject to limitations specified in DHR standards; licensed applied psychologists, limited to 24 hours per calendar year; psychiatrists, limited to 12 hours per calendar year.

**Inpatient Substance Abuse Treatment Services**
Services are covered only for short-term acute care in general acute care hospitals up to 30 days per admission. Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered.

**Residential Substance Abuse Treatment Services**
Services are covered only for short-term acute care in general acute care hospitals up to 30 days per admission. Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered.

**Outpatient Substance Abuse Treatment Services**
Services are covered through Community Mental Health Centers, subject to limitations specified in DHR standards.

**Durable Medical Equipment**
Includes other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). Durable medical equipment and supplies prescribed by a physician are covered. Prior approval is required for custom molded shoes and for repairs to certain prosthetic devices. Medical equipment purchases and one-way mileage for delivery in excess of $200 require prior approval.

**Preventive Dental Services**
Dental and oral surgical services are covered as follows: two visits (initial or periodic) for dental exams/screens, and two emergency exams during office hours per calendar year without prior approval.

**Restorative Dental Services**
One restorative (filling) procedure per tooth per restoration, sealants for first and second permanent molars only; and orthodontic services with prior approval.

**Hearing Aids**
Hearing aids are allowed every three years without prior approval. Medical necessity for hearing aids must be approved by Children's Medical Services. Prior approval is based upon the completion of a hearing evaluation by the prescribing physician or other licensed practitioner.

**Vision Screening**
Services include refraction, dispensing fees, and other refractive services are covered. Medically necessary diagnostic services are also covered. Limitations are 1 refractive exam per calendar year.

**Corrective Lenses (including eyeglasses)**
Eyeglasses are included. Prior approval is required for other services including, but not limited to: contact lenses, trifocal lenses, oversized frames, hi-index and polycarbonate lenses. One refractive exam, optical device, fitting, and dispensing fee per calendar year are covered. Additional such services require prior approval.

**Immunizations**
Regular physical exams (screenings), health tests, immunizations and treatment for diagnosed problems are covered. Screening requirements are based on the recommendations for preventive pediatric health care adopted by the American Academy of Pediatrics. Treatment is covered within the limitations on covered services.

**Well-baby Visits**
Regular physical examinations (screening), health tests, immunizations and treatment for diagnosed problems are covered. Screening requirements are based on the recommendations for preventive pediatric health care adopted by the American Academy of Pediatrics. Treatment is covered within the limitations on covered services.

**Well-child Visits**
Regular physical examinations (screening), health tests, immunizations and treatment for diagnosed problems are covered. Screening requirements are based on the recommendations for preventive pediatric health care adopted by the American Academy of Pediatrics. Treatment is covered within the limitations on covered services.

**Physical Therapy**
One hour per day up to ten hours per calendar month is covered. With prior approval, this limit may be exceeded. Physical therapy is covered for children from birth through 18 years of age. Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in the *Policy and Procedure Manual* have been reached. Individualized Family Service Plan is required to document medical necessity for amount, duration and scope of services

**Speech Therapy**
One session per day up to ten sessions per month is covered. With prior approval, these limits may be exceeded. Speech-language pathology is covered for children from birth through 18 years of age. Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in *the Policy and Procedure Manual* have been reached. Individualized Family Service Plan is required to document medical necessity for amount, duration and scope of services. Note that children 18 years of age are not covered under these program services.

**Occupational Therapy**
One hour per day up to ten hours per calendar month is covered. With prior approval, these limits may be exceeded. Occupational therapy is covered for children from birth through 18 years of age. Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in the *Policy and Procedure Manual* have been reached. Individualized Family Service Plan is required to document medical necessity for amount, duration and scope of services.

**Podiatry Services**
Services covered are diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of ailments of the foot or leg as authorized within the Georgia statue governing podiatry services.

**Medical Transportation**
Emergency ambulance services are covered for an enrollee whose life and/or health is in danger. Non-emergency transportation is not covered.

**Home Health Services**
Home health services ordered by a physician and provided in the enrollee's home, including part-time nursing services, physical, speech and occupational therapy, and home health services covered for 75 visits per calendar year. Home health services exceeding 75 visits may be covered when requested by a physician and determined to be medically necessary by DMA.

**Hospice Care**
Covered under a plan of care when provided by an enrolled hospice provider.

**Surgical Services**
Services (including inpatient and outpatient surgical services) are covered in full. Prior approval is needed for certain procedures.

**Nursing Care Services**
Nurse Practitioner Services Program reimburses for a broad range of medical services provided by Participating Pediatric, Family, Adult, and OB/GYN Nurse Practitioners, and Certified Registered Nurse Anesthetists (CRNA). Lab tests for purposes of family planning provided by a nurse practitioner are covered. Medically necessary office and nursing facility evaluation and management are covered. Nurse Midwives are covered.

**End Stage Renal Disease**
Service and procedures designed to promote and maintain the functioning kidney and related organs are covered when provided by a provider enrolled in the ESDR program. Acute renal dialysis services are covered under other programs.

**Physician's Assistant Services**
Covered services are limited to primary care services and anesthesiologist's assistant services authorized in the respective job description, which is approved by the Georgia Composite State Board of Medical Examiners.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

***Table 3.2.3***

| Type of delivery system | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
|---|---|---|---|
| A. Comprehensive risk managed care organizations (MCOs) | | 0% | |
| Statewide? | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Mandatory enrollment? | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Number of MCOs | | | |
| B. Primary care case management (PCCM) program | | 100% | |
| C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable) | | No | |
| D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable) | | All GBHC services are reimbursed on a fee-for-service schedule. Mental, vision and dental health care do not require a referral from the GBHC PCP. | |
| E. Other (specify) | | | |
| F. Other (specify) | | | |

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, and co-insurance/co-payments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

✓ Yes, check all that apply in Table 3.3.1

***Table 3.3.1***

| **Type of cost-sharing** | **Medicaid CHIP Expansion Program** | **State-designed CHIP Program** | **Other CHIP Program*** _____ |
|---|---|---|---|
| Premiums | | ✓ | |
| Enrollment fee | | | |
| Deductibles | | | |
| Coinsurance/co-payments** | | | |
| Other (specify) _____ | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".
**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

PeachCare for Kids does not require premiums for children ages 5 and younger. Children ages 6 and older must pay a monthly premium of $7.50 for one child and $15 for two or more children in the same household. The maximum a family would pay is $180 annually for all children in the household. There are no co-payments, deductibles or enrollment fees for PeachCare.

Premiums are due on the first day of the month prior to the month of coverage. Families receive a coupon book to assist with the payment of the premium, and families may also choose to pay for multiple months in advance. Families who have not paid the monthly premium are sent letters around the 3rd of the month, and a second letter is mailed around the 7th to families who have not made the monthly payment. If payment is not received by the date that eligibility is

determined for the following month (typically around the 20th of the month), coverage is cancelled.

Late payments, unless otherwise indicated by the family, are applied to reinstate the children for the following month. Reinstatement does not require a waiting period.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

- ✓ Employer
- ✓ Family
- ✓ Absent parent
- ✓ Private donations/sponsorship
- ___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria? N/A

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)? N/A

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

The application and program descriptions describe the premiums. PeachCare for Kids only requires premium payments for children ages 6 and older. There are no co-payments or other out-of-pocket expenditures incurred for covered benefits. Through this payment schedule, no family will pay more than $180 per year, guaranteeing that expenditures will not exceed 5% of annual income.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

- ___ Shoebox method (families save records documenting cumulative level of cost sharing)
- ___ Health plan administration (health plans track cumulative level of cost sharing)
- ___ Audit and reconciliation (State performs audit of utilization and cost sharing)
- ✓ Other (specify)

By having a low premium that never exceeds $180 per year for a family, we are assured that aggregate cost sharing never exceeds 5% of the family income.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

In our disenrollee survey, we found that cost is infrequently the reason for disenrollment (less than 1% of families disenrolled due to cost). In our focus groups, families told us the premium is very affordable.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (✓ = yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

***Table 3.4.1***

| Approach | Medicaid CHIP Expansion | | State-Designed CHIP Program | | Other CHIP Program* _____ | |
|---|---|---|---|---|---|---|
| | ✓ = Yes | Rating (1-5) | ✓ = Yes | Rating (1-5) | ✓ = Yes | Rating (1-5) |
| Billboards | | | ✓ | 2 | | |
| Brochures/flyers | | | ✓ | 5 | | |
| Direct mail by State/enrollment broker/administrative contractor | | | | | | |
| Education sessions | | | ✓ | 4 | | |
| Home visits by State/enrollment broker/administrative contractor | | | ✓ | 4 | | |
| Hotline | | | ✓ | 5 | | |
| Incentives for education/outreach staff | | | | | | |
| Incentives for enrollees | | | | | | |
| Incentives for insurance agents | | | | | | |
| Non-traditional hours for application intake | | | ✓ | 5 | | |
| Prime-time TV advertisements | | | ✓ | 5 | | |
| Public access cable TV | | | | | | |
| Public transportation ads | | | ✓ | 2 | | |
| Radio/newspaper/TV advertisement and PSAs | | | ✓ | 5 | | |
| Signs/posters | | | ✓ | 3 | | |

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

***Table 3.4.2***

| Setting | Medicaid CHIP Expansion | | State-Designed CHIP Program | | Other CHIP Program* | |
|---|---|---|---|---|---|---|
| | ✓ = Yes | Rating (1-5) | ✓ = Yes | Rating (1-5) | ✓ = Yes | Rating (1-5) |
| Battered women shelters | | | | | | |
| Community sponsored events | | | ✓ | 5 | | |
| Beneficiary's home | | | | | | |
| Day care centers | | | ✓ | 3 | | |
| Faith communities | | | ✓ | 3 | | |
| Fast food restaurants | | | | | | |
| Grocery stores | | | | | | |
| Homeless shelters | | | ✓ | 3 | | |
| Job training centers | | | ✓ | 3 | | |
| Laundromats | | | | | | |
| Libraries | | | ✓ | 3 | | |
| Local/community health centers | | | ✓ | 5 | | |
| Point of service/provider locations | | | ✓ | 5 | | |
| Public meetings/health fairs | | | ✓ | 4 | | |
| Public housing | | | ✓ | 3 | | |
| Refugee resettlement programs | | | | | | |
| Schools/adult education sites | | | ✓ | 5 | | |
| Senior centers | | | | | | |
| Social service agency | | | ✓ | 4 | | |
| Workplace | | | ✓ | 4 | | |

4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

One of the methods used to assess outreach effectiveness was the new enrollee survey. Approximately 41 percent of those surveyed (1,756 total) reported that they had heard about PeachCare for Kids in advertisements, while 12 percent stated they had heard of the program through outreach/case/DFACS workers. (Thirty one percent of new enrollees also indicated that they heard about PeachCare through friends/family members/church, while others heard about it through their health care provider (22%), the public health department (19%), news sources (12%), schools (8%), and others (8%).

One year after statewide implementation, PeachCare reached its two-year enrollment goal with 60,054 children enrolled on January 1, 2000. With over 70,000 enrollees to date, we know that our marketing campaign has been successful and has worked to motivate many people to apply. In year two, we will place our focus on hard to reach populations (See Table 4).

To further ascertain why hard to reach eligible families have not enrolled in PeachCare for Kids, we conducted focus groups. These groups were African-Americans, (some urban, and some rural), a rural racially mixed group, a Hispanic group, and one group of parents of adolescents. Two issues of particular interest of the focus groups were: perceptions of PeachCare marketing efforts and its effectiveness in motivating applicants; and motivations necessary to promote trial suggestions for marketing PeachCare for Kids. We can use the information from the focus groups to attract this eligible non-participating population.

Table 4

| *Attributes of Population* | *Total Uninsured Children** | *Eligible for PeachCare for Kids** | *PeachCare for Kids Enrollees* |
|---|---|---|---|
| | 376,769 | 119,558 (32%) | 47,584 (40%) |
| **Race/Ethnicity** | | | |
| Black, non-Hispanic | 157,054 (42%) | 37,705 (32%) | 14,482 (30%) |
| Hispanic* | 26,584 (7%) | 6,111 (5%) | 1,378 (3%) |
| White, non-Hispanic | 180,047 (48%) | 74,646 (62%) | 28,977 (61%) |
| Other | 13,086 (3%) | 1,096 (1%) | 805 (2%) |
| Unknown | | | 1,942 (4%) |
| **Location** | | | |
| MSA- Urban | 220,936 (59%) | 86,223 (48%) | 23,914 (50%) |
| MSA – Rural | 155,834 (41%) | 61,345 (52%) | 13,922 (29%) |
| Unknown | | | 9,748 (20%) |

SOURCE: Current Population Survey combined 1997, 1998, 1999 data and estimated PeachCare enrollment data
*Sample size is very small and numbers should be used with caution.

Table compiled by Georgia Health Policy Center, 02/16/2000

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

PeachCare has used various communication approaches to target eligible families of different ethnic backgrounds. An example of which is when PeachCare for Kids participated in "For Sisters Only," an event attended primarily by African-American women. This event coordinated by V-103, an Atlanta area radio station, draws over 60,000 women each year. PeachCare was the official sponsor of the McDonald's Kids Corner. As children enjoyed the play area, the PeachCare outreach staff was available with program information and applications for the parents. In addition to being part of the event, V-103 did on-air interviews with PeachCare representatives before and during the event.

We have also based our communication approaches on responses from our focus groups of non-participating eligible families, which included groups of African-American and Hispanic parents. The information gathered from these groups assisted in the development of the outreach activities for the second year of the program. The preliminary results of the groups have directed PeachCare to refine the information and messages that are promoted in the marketing materials. We learned that parents are very positive about PeachCare for Kids' broad benefits and low cost, and that these features should be emphasized in the marketing. They were also impressed with the large choice of providers that makes it likely that they will be able to keep their own provider. These important issues will be used to enhance the information provided in future brochures and flyers.

With the assistance of the Georgia Health Policy Center, the Department of Community Health awarded 25 mini-grants to organizations to conduct targeted outreach for PeachCare for Kids and Medicaid. Grant monies were made available through a competitive process to community based groups conducting outreach to hard-to-reach populations within the state. The purpose of these grants is to reach our non-participating eligible families in non-traditional ways. Issues of trust, cultural variances, immigration status, language differences, and illiteracy are often barriers and reasons that traditional approaches do not reach our non-participating families. Based on these issues and barriers, our outreach is community-centered. Results of the mini-grant program will be available in August.

The following table (Table 5) includes the outreach activities of our mini-grants to date, and those planned for FY 2000.

Table 5

***Communication Approaches***

| **Target Population** | **Outreach Activity** |
|---|---|
| Homeless population | - PeachCare materials distributed during intake process to homeless shelters |
| Various ethnic backgrounds in Fulton, Clayton, DeKalb Counties | - PeachCare educational workshops<br>- Community canvass as part of the Martin Luther King Jr. summit |
| Hispanic - rural/African-American/White | - PeachCare seminars to community businesses/industries<br>- Christmas Parade - Sponsor PeachCare Float/Valentine Teas at local PTAs and PTOs<br>- Qualification process for free school lunch program to identify and enroll PeachCare and Medicaid eligibles<br>- Inform teacher, principals, school nurses, and guidance counselors about PeachCare and Medicaid |
| Hispanic families | - PeachCare presentations at PTA meetings across the county<br>- Distribution of PeachCare literature at retail outlets, grocery stores, churches, medical maternity floors, and stadium during Hispanic culture day and soccer matches<br>- Sponsorship, development and distribution of PeachCare materials at health fairs<br>- Door-to-door canvassing |
| Asian/Pacific Islanders | - Translation and distribution of PeachCare materials<br>- Training of staff, community assistance providers, and outreach workers in assisting with PeachCare application process |
| Working poor/entry level salaried workers/Hispanic families | - Design of PeachCare promotional materials for newspaper ads, posters, and flyers (distribution of flyers via utility bills and paychecks)<br>- Sponsor of PeachCare sign-ups at local businesses and agencies (daycare centers and United Way agencies) |
| African-American families | - Design and distribution of flyers, and door-to-door campaign<br>- Workshops at community centers and churches<br>- Local radio and television PSAs |
| Families with disabled children | - PeachCare inservice trainings of staff<br>- PeachCare information distribution at local churches, Head Start programs, and daycare centers |
| Pre-K, Elementary, Middle School Children | - Attendance at PTO meetings for PeachCare awareness and application assistance<br>- On-site services at elementary and middle schools to allow parents to ask questions about PeachCare<br>- Display of PeachCare bulletin boards at schools |
| Low to Middle income families in a cultural, racial or ethnic minority | - Promotion PeachCare and Medicaid through bimonthly newsletter distributed to every P.O. and Rural Route Box holder in county<br>- Door to door campaign and health fair |

| | |
|---|---|
| Rural families | - Public service announcements recorded by well known community members<br>- Local Christmas Parade - PeachCare sponsored booth<br>- PeachCare information distribution at Community Festival<br>- PeachCare presentations-local churches/child care centers/PTAs/business civic clubs<br>- PeachCare billboards in high traffic areas<br>- Radio announcements, newspaper ads, newsletters, and local television shows<br>- PeachCare booths set up throughout county for distribution of PeachCare info/application assistance<br>- PeachCare displays at local businesses<br>- Organization/Employer presentations regarding PeachCare<br>- Monthly news articles regarding PeachCare, table mats in restaurants, flyers in grocery bags and local phone bills<br>- Letter writing campaign to local businesses sponsored by after school program inquiring whether PeachCare is available to employees<br>- Distribute PeachCare literature and materials to fast food restaurants and small businesses to pass on to their employees<br>- Distribute PeachCare literature to parents receiving infant and toddler car seats, to new families at the Marine Logistics Base, and at health fairs<br>- Confidential mailings via hospital/Board of Education to target children not enrolled in heath insurance and participating in free/reduced lunch program |
| Families in local housing development | - PeachCare presentation - Local Education Program/ job search classes<br>- Local health fair - Sponsor PeachCare booth/assistance with PeachCare application |
| Minority children | - Parent sessions regarding PeachCare/Medicaid at Head Start programs, kindergartens, public schools<br>- Health fairs and distribution of PeachCare information at apartment complexes, grocery stores, laundries, beauty shops |
| Families/minorities in rural areas | - PeachCare presentations/PeachCare literature distribution at parent/teacher conference series and in school report cards<br>- Weekly visits to local battered women's shelter to increase awareness and distribute PeachCare literature<br>- Distribute information adult literacy conference<br>- Sponsor PeachCare booths at retail outlets during Christmas and local festivals |
| Parents seeking employment and Local Businesses | - PeachCare promotion at specific job fairs, United Way job fairs, and Goodwill job placement services<br>- Design and distribute PeachCare paycheck stuffers |

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Currently, our new enrollee survey responses indicate that our advertisements have been most successful at reaching African-American, and family/friends/churches have been most successful at reaching Hispanics (see Table 6 below).

PeachCare for Kids also monitors phone volume for an estimate of the effectiveness of certain outreach activities. With the distribution of 1.4 million flyers to children enrolled in public schools, phone volume and application requests were monitored as an indication of the success of the effort. During the first six weeks of the new school year, as the flyers were being distributed, an average of 800 applications were requested per day - an increase of 400% over the average of 200 request per day in the prior weeks.

Since our mini-grants were awarded funding in September 1999, their effectiveness may be evaluated as soon as August 2000 (FFY 2000).

Table 6

**How did you hear about PeachCare?**

| | White | African-American | Hispanic | Other/Multi-racial |
|---|---|---|---|---|
| Advertisement | 40% | 46% | 20% | 60% |
| News | 14% | 10% | 0 | 12% |
| Healthcare Provider | 21% | 22% | 26% | 28% |
| Family/Friend/Church | 30% | 32% | 32% | 40% |
| School | 8% | 5% | 15% | 15% |
| Public Health Dept. | 19% | 17% | 26% | 29% |
| Outreach/Caseworker | 10% | 16% | 8% | 22% |
| Other | 8% | 8% | 6% | 13% |

SOURCE: New enrollee survey, respondents were enrolled January - December 1999. Column totals exceed 100% because respondents could choose more than one source from which they heard about PeachCare.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch).

Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

| ***Table 3.5*** | | | | | |
|---|---|---|---|---|---|
| Type of coordination | Medicaid* | Maternal and child health | Other (specify) Local Public Health Department | Other (specify) DFACS | Other (specify) Uninsured - GA Partnership for Caring |
| Administration | ✓ | | | | |
| Outreach | ✓ | | ✓ | ✓ | ✓ |
| Eligibility determination | ✓ | | | ✓ | |
| Service delivery | ✓ | | ✓ | | |
| Procurement | ✓ | | | | |
| Contracting | ✓ | | | | |
| Data collection | ✓ | | | | |
| Quality assurance | ✓ | | | | |
| Other (specify) | | | | | |

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.
See Section 2.2.1 regarding CHIP coordination with other programs.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

✓ Waiting period without health insurance (specify) 3 months
✓ Information on current or previous health insurance gathered on application (specify).

PeachCare for Kids has implemented a three-month waiting period in which enrollees must be uninsured before they are enrolled in CHIP. A child is denied eligibility if: s/he is eligible for Medicaid; it is determined that s/he voluntarily terminated coverage under an employer plan during the past three months; s/he is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; s/he is a member of a family eligible for health benefits under a State health benefit plan based on a family member's employment with a public agency in the state.

Employer information is also validated by checks of wage record data with the Georgia Department of Labor when available. Once children are enrolled, the labor department files are periodically checked to determine whether there have been changes in employers. The PeachCare for Kids application contains questions about current and past coverage under group health plans and family members' employment with State agencies.

Voluntary termination of coverage does NOT include the following: employer cancellation of the entire group plan; loss of eligibility due to parent's layoff; resignation of parent from employment; employment termination; leave of absence without pay; or reduction of work hours; cancellation of COBRA or an individual policy. The PeachCare for Kids application contains questions about current and past coverage under group health plans and family members' employment with state agencies. Eligibility for a state plan is checked electronically, and enrollment in Medicaid is checked electronically as well. Employer information is also validated by checks of wage record data with the Department of Labor when available.

___ Information verified with employer (specify) _____
✓ Records match (specify) _____

State benefit plan eligibility, Medicaid enrollment, and the Department of Labor perform checks after enrollment.

___ Benefit package design:
- ___ Benefit limits (specify) _____
- ___ Cost-sharing (specify) _____
- ___ Other (specify _____
- ___ Other (specify) _____

___ Other policies intended to avoid crowd out (e.g., insurance reform):
- ___ Other (specify) _____
- ___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Because of the limitations of CPS and other data sources, we cannot detect disenrollment in private and public insurance programs due to PeachCare for Kids.

## SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

| ***Table 4.1.1 CHIP Program Type*** State-designed CHIP Program | | | | | | |
|---|---|---|---|---|---|---|
| Characteristics | Number of children ever enrolled | | Average number of months of enrollment* | | Number of disenrollees** | |
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| **All Children** | N/A | 47,584 | N/A | | N/A | 4,879 |
| | | | | | | |
| **Age** | | | | | | |
| Under 1 | | 398 | | | | 33 |
| 1-5 | | 13,794 | | | | 719 |
| 6-12 | | 23,023 | | | | 2,806 |
| 13-18 | | 10,369 | | | | 1,321 |
| | | | | | | |
| **Countable Income Level*** | | | | | | |
| At or below 150% FPL | | 27,591 | | | | 3,273 |
| Above 150% FPL | | 19,993 | | | | 1,606 |
| | | | | | | |
| **Age and Income** | | | | | | |
| Under 1 | | | | | | |
| At or below 150% FPL | | 0 | | 0 | | 0 |
| Above 150% FPL | | 398 | | 1.68 | | 33 |
| | | | | | | |
| 1-5 | | | | | | |
| At or below 150% FPL | | 5,725 | | 1.84 | | 348 |
| Above 150% FPL | | 8,069 | | 1.92 | | 371 |
| | | | | | | |
| 6-12 | | | | | | |
| At or below 150% FPL | | 15,017 | | 1.84 | | 1,992 |
| Above 150% FPL | | 8,006 | | 1.92 | | 814 |
| | | | | | | |
| 13-18 | | | | | | |
| At or below 150% FPL | | 6,849 | | 1.89 | | 933 |
| Above 150% FPL | | 3,520 | | 1.95 | | 388 |
| | | | | | | |
| **Type of plan** | | | | | | |
| Fee-for-service | | | | | | |
| Managed care | | | | | | |
| PCCM | | 47,584 | | | | |

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, 64.21E, 64EC, Statistical Information Management System.

*Average number of months of enrollment does not indicate average length of enrollment as the calculation does not reflect ongoing enrollment.

**Disenrollment numbers may double count individuals who have enrolled and disenrolled in the program more than once during the year.

| ***Table 4.1.1 CHIP Program Type*** State-designed CHIP Program | | | | |
|---|---|---|---|---|
| Characteristics | Number of children ever enrolled | | Number of disenrollees | |
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| **All Children** | | **47,584 | | |
| **Race/Ethnicity** | | | | |
| White, non-Hispanic | | 28,977 | | |
| Black, non-Hispanic | | 14,482 | | |
| Hispanic | | 1,378 | | |
| Other | | 805 | | |
| Unknown | | 1,942 | | |
| | | | | |
| **Location** | | | | |
| MSA/Urban | | 28,788 | | |
| Non-MSA/Rural | | 18,796 | | |

SOURCE: ** Estimated PeachCare enrollment data - Claims Data, September 30, 1999.

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Based on our new enrollee survey, 17% of the respondents reported that they had had insurance to help with the cost of care in the past year, with 12 percent of these respondents reporting that this insurance was through a job.

SOURCE: New Enrollee Random Survey of 500 new enrollees per month with 44 percent response rate conducted by Georgia Health Policy Center, Georgia State University, 1999.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

The only other public insurance program in the state is Medicaid, which covered 690,220 children in Georgia in State Fiscal Year 1998. CPS data shows that there are approximately 147,000 more eligible children.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

In FFY 1999, 4,879 children disenrolled from PeachCare for Kids. Based upon comparisons with disenrollment rates in other states, we had expected that our disenrollment rates would be approximately 10% of our enrollment. Table 7 shows the primary reasons for disenrollment.

Table 7

**PeachCare for Kids Voluntary Disenrollment based on Survey of Disenrollees****

| | **Families** | **Percent** |
|---|---|---|
| **Reason for disenrollment** | | |
| Got other insurance* | 521 | 40% |
| Fell behind on payments | 253 | 20% |
| Cost too much | 141 | 11% |
| Income changed (increase/decrease) | 133 | 10% |
| Plan didn't meet expectations | 112 | 9% |
| No longer needed healthcare | 27 | 2% |
| Deceased | 5 | 0 |
| Unable to find dentist | 11 | 1% |
| Employer stopped paying premiums | 5 | 0 |
| Other/known reason | 85 | 7% |
| Total | 1,293 | 100% |

SOURCE: Disenrollee survey with 44% response rate conducted by Georgia Health Policy Center, Georgia State University, 1999.

*In a later question, an additional 20% reported they had since obtained other health insurance, for a total of 60% of disenrollees currently insured through other sources.

**People were surveyed only when their reason for disenrollment was not apparent from administrative records.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Because the program has only been operational just over one year, we do not yet have data on the number of children who did not re-enroll at renewal. We know from the disenrollee survey that approximately 60% of disenrollees have obtained other health insurance.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

***Table 4.2.3***

| Reason for discontinuation of coverage | Medicaid CHIP Expansion Program | | State-designed CHIP Program PeachCare | | Other CHIP Program* | |
|---|---|---|---|---|---|---|
| | Number of disenrollees | Percent of total | Number of disenrollees | Percent of total | Number of disenrollees | Percent of total |
| Total | | | 2,512 | | | |
| Access to commercial insurance* | | | 521 | 21% | | |
| Eligible for Medicaid† | | | 789 | 31% | | |
| Income too high | | | | | | |
| Aged out of program† | | | 105 | 4% | | |
| Moved/died† | | | 69 | 3% | | |
| Nonpayment of premium* | | | 258 | 10% | | |
| Incomplete documentation | | | | | | |
| Did not reply/unable to contact | | | | | | |
| Other(specify) Became active again† | | | 221 | 9% | | |
| Other (specify) Plan didn't meet expectations* | | | 112 | 4% | | |
| Other (specify) Cost too much* | | | 141 | 6% | | |
| Other (specify) Unable to find dentist* | | | 11 | 0.4% | | |
| Other (specify) No longer needed healthcare* | | | 27 | 1% | | |
| Other (specify) Income changed (up or down)* | | | 133 | 5% | | |
| Other (specify) Merit System match/State employee* | | | 40 | 2% | | |
| Other/Unknown reason* | | | 85 | 3% | | |

SOURCE: Claims Data and Disenrollee Survey. Survey (with 44 percent rate) was conducted by Georgia Health Policy Center, Georgia State University, 1999.

* Families who voluntarily disenrolled from the program and whose reason for disenrollment was not apparent from administrative records.
† Families disenrolled by the program because they were no longer eligible.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Participants are reminded of the re-enrollment procedure in the cancellation letter and the disenrollee survey.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 N/A

FFY 1999 $10,270,740 (total computable share)

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

***Table 4.3.1 CHIP Program Type*** State-designed Program

| Type of expenditure | Total computable share | | Total federal share | |
|---|---|---|---|---|
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| **Total expenditures** | N/A | 10,270,740 | N/A | 7,428,826 |
| | | | | |
| **Premiums for private health insurance (net of cost-sharing offsets)*** | N/A | (932,775) | N/A | (674,676) |
| | | | | |
| **Fee-for-service expenditures (subtotal)** | N/A | 10,701,091 | N/A | 7,740,099 |
| Inpatient hospital services | N/A | 887,263 | N/A | 641,757 |
| Inpatient mental health facility services | N/A | 0 | N/A | 0 |
| Nursing care services | N/A | 35,969 | N/A | 26,016 |
| Physician and surgical services | N/A | 1,952,801 | N/A | 1,412,461 |
| Outpatient hospital services | N/A | 1,879,787 | N/A | 1,359,650 |
| Outpatient mental health facility services | N/A | 0 | N/A | 0 |
| Prescribed drugs | N/A | 2,207,369 | N/A | 1,596,590 |
| Dental services | N/A | 1,804,524 | N/A | 1,305,212 |
| Vision services | N/A | 191,687 | N/A | 138,647 |
| Other practitioners' services | N/A | 222,681 | N/A | 161,065 |
| Clinic services | N/A | 354,693 | N/A | 256,549 |
| Therapy and rehabilitation services | N/A | 4,584 | N/A | 3,316 |
| Laboratory and radiological services | N/A | 21,409 | N/A | 15,485 |
| Durable and disposable medical equipment | N/A | 64,417 | N/A | 46,593 |
| Family planning | N/A | 3,019 | N/A | 2,184 |
| Screening services | N/A | 410,432 | N/A | 296,865 |
| Home health | N/A | 154 | N/A | 111 |
| Home and community-based services | N/A | 0 | N/A | 0 |
| Hospice | N/A | 0 | N/A | 0 |
| Medical transportation | N/A | 18,954 | N/A | 13,709 |
| Case management | N/A | 634,941 | N/A | 459,253 |
| Other services | N/A | 6,407 | N/A | 4,634 |

*Total expenditures equals Fee-for-Service (benefits) expenditures in Table 4.3.1 plus administrative expenses in Table 4.3.2 minus the premiums in Table 4.3.1.

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? PeachCare for Kids funded a variety of functions under the 10 percent cap, including general administrative costs, such as staff, enrollment and account maintenance, and outreach activities as detailed in Table 3.4.1 and within Section 3.4.4.

What role did the 10 percent cap have in program design? Due to the the commitment of the State to ensure uninsured children are aware of and enrolled in PeachCare for Kids, the 10 percent cap did not affect the program's ability to implement a successful program. Without the dedication of the State to supply unmatched funds, PeachCare would not have been able to exceed enrollment projections.

***Table 4.3.2***

| **Type of expenditure** | Medicaid Chip Expansion Program | | State-designed CHIP Program | | Other CHIP Program* | |
|---|---|---|---|---|---|---|
| | FY 1998 | FY 1999 | FY 1998 | FY 1999 | FY 1998 | FY 1999 |
| **Total computable share** | | | | 502,420 | | |
| Outreach | | | | - | | |
| Administration | | | | 502,420 | | |
| Other_____ | | | | - | | |
| **Federal share** | | | | 363,400 | | |
| Outreach | | | | - | | |
| Administration | | | | 363,400 | | |
| Other _____ | | | | - | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

✓ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
✓ Other (specify) ___Family Premiums_____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

***Table 4.4.1***

| **Approaches to monitoring access** | **Medicaid CHIP Expansion Program** | **State-designed CHIP Program** | **Other CHIP Program* _____** |
|---|---|---|---|
| Appointment audits | | N/A | |
| PCP/enrollee ratios | | PCCM | |
| Time/distance standards | | PCCM | |
| Urgent/routine care access standards | | PCCM | |
| Network capacity reviews (rural providers, safety net providers, specialty mix) | | N/A | |
| Complaint/grievance/ Disenrollment reviews | | PCCM | |
| Case file reviews | | N/A | |
| Beneficiary surveys | | PCCM | |
| Utilization analysis (emergency room use, preventive care use) | | PCCM | |
| Other (specify) External program evaluation | | PCCM | |
| Other (specify) Medical Records Review | | PCCM | |
| Other (specify) Satisfaction surveys | | PCCM | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

***Table 4.4.2***

| Type of utilization data | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
|---|---|---|---|
| Requiring submission of raw encounter data by health plans | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Requiring submission of aggregate HEDIS data by health plans | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Other (specify) _____ | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Our data indicate that PeachCare for Kids is off to a good start. To measure access to care, we surveyed our enrollees who had been in PeachCare for at least six months (response rate = 70%). We found:

- 66% of enrollees were able to keep their PCP when they joined PeachCare. Thirty four percent (34%) of PeachCare parents responded that they changed to a new doctor/nurse when they joined PeachCare, and of these 82% said they did not have a problem in finding a doctor or nurse that they were happy with.
- 93% of parents said that they usually or always got the help they needed when they contacted their doctor's office during regular office hours to get help or advice.
- 91% reported that when their child was injured or became ill, they were able to get the needed care right away.
- 86% stated that their child received a new prescription or refill when they needed it.
- For those respondents that called customer service to get information, 88% reported getting the help they needed with PeachCare.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

**Information Strategies**

We intend to give feedback information on performance to PCPs so that they are aware of how they are doing in meeting the objectives of PeachCare. Feedback of this kind has been shown to result in provider behavior change. We will also consider adding financial incentives in future years to encourage achievement of these objectives.

Based on the findings of our evaluation, we will identify quality improvement projects in the second year of PeachCare for Kids. DMA is in the process of discussing a project to improve asthma management with some of the providers in the state. Another plan may include preventable hospital visits, and AAP Standards for well-child visits. In summarization, we will monitor access and quality standards in feedback in subsequent years. Data may be available in September 2000.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

***Table 4.5.1***

| **Approaches to monitoring quality** | **Medicaid CHIP Expansion Program** | **State-designed CHIP Program** | **Other CHIP Program** |
|---|---|---|---|
| Focused studies (specify) | | | |
| Client satisfaction surveys | | PCCM | |
| Complaint/grievance/ Disenrollment reviews | | PCCM | |
| Sentinel event reviews | | PCCM | |
| Plan site visits | | | |
| Case file reviews | | | |
| Independent peer review | | | |
| HEDIS performance measurement | | PCCM | |
| Other performance measurement (specify) Health Check | | PCCM | |
| Other (specify) Credentialing/Recredentialing | | PCCM | |
| Other (specify) Quarterly Utilization Review | | PCCM | |
| Other (specify) Medical Records Review | | PCCM | |

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Based on the CAHPS survey of PeachCare families, we know that enrollees are receiving quality care and that PeachCare is off to a good start. The families rate the quality of providers and plan very high. The following are our CAHPS Survey Highlights:

| Overall Quality Rating of: | Percentage Very Satisfied* |
|---|---|
| Personal doctors or nurses | 87% |
| Specialists | 87% |
| All health care providers and doctors | 91% |
| Dentists | 86% |
| Equipment, services and help | 93% |
| All experiences with PeachCare for Kids | 86% |

SOURCE: Georgia Health Policy Center, PeachCare for Kids CAHPS 2.0 Survey, February 2000.

*Very Satisfied = people with positive responses rated 7 to 10 on a scale of 1 to 10.

The CAHPS survey results have additional details regarding quality of care, which we have not yet analyzed. A full report will be available in April 2000.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

The performance measures are listed below:

- Percent of children receiving each screening or completing each visit on or about the recommended schedule.
- Percent of children receiving immunizations on or about the recommended schedule.
- Percent of children being hospitalized for conditions that could have been treated earlier on an outpatient basis (preventable hospitalizations).
- Percent of children being referred repeatedly to the emergency department for care that might be provided in a PCP office.
- Percent of children with asthma receiving appropriate care, as defined by national standards.
- Percent of parents satisfied with the care their child is receiving.

See Section 1.3 for available data dates.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

## SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

The mail-in application, supported by the toll-free number, has been cited by parents as a simple process that meets their needs (sources: new enrollee survey and focus groups). The application does not require cumbersome documentation that places undue burden on parents to prove their children's eligibility. Assistance with the application is available from 7:30 a.m. until 7:30 p.m. According to the new enrollee survey, 67% of the parents have used the toll-free number to request an application or inquire about the program. Parents tend to call with questions about provider choice, eligibility requirements, pre-existing condition limitations, and benefits.

Maintaining coverage once enrolled is also simple for the families. While premiums are charged for children over the age of 6, an evaluation of voluntary disenrollment by the Georgia Health Policy Center shows that only 141 PeachCare families disenrolled from the program due to cost and 253 disenrolled when they accidentally got behind on premiums.

PeachCare applications of potentially Medicaid-eligible children are sent to the RSM team for processing. This eligibility determination does not require any intervention on the part of the parent to initiate. The RSM team contacts the families if additional information is needed (e.g. children have other insurance, do not have a Social Security number). This process does not require a face-to-face interview and is as simple as possible to facilitate the children in gaining coverage under Medicaid.

The redetermination process for PeachCare for Kids is designed to maintain coverage for the children by reducing artificial barriers to coverage. The process employs the same standards of self-declaration as the original application. Families are sent all pertinent information on the account and are directed to call to report any changes. If there are no changes, PeachCare for Kids does not

require any action by the parent to maintain coverage, as long as all applicable premiums are paid.

The redetermination process for children enrolled in Medicaid through a PeachCare for Kids application is handled by mail, reducing the need for appointments, travelling to an office, or a face-to-face interview. As the cases are maintained by DFACS, the redetermination application must be completed and submission of documentation is required. The application includes information for Food Stamps, cash assistance and other social service programs.

### 5.1.2 Outreach

PeachCare for Kids has developed a successful major media campaign that was created to raise awareness of the program. The media campaign has a private market appeal that attracts families who may have reservations about applying for a public program. The campaign also attracts parents of Medicaid eligible children who assume their income is too high for Medicaid coverage. As with most major media efforts, the campaign is effective in reaching a broad range of the population. It must, however, be enhanced to find the hard-to-reach populations.

To target hard-to-reach populations, Georgia has initiated several community-based approaches. The Right from the Start Medicaid program is able to provide grassroots outreach throughout local communities. With a focus on non-traditional work hours and non-traditional locations, they are able to contact working families that might not be reached through broad-based outreach efforts. In addition, the mini-grant program provided 25 community-based organizations with the support to conduct targeted outreach in their communities.

The greatest challenge in implementing an effective outreach program is the administrative cap on funding through Title XXI. There has been overwhelming enthusiasm by advocates, community groups, and individuals who are willing to promote PeachCare for Kids. We are limited, however, in the amount of materials that we are able to produce. As the need for awareness is more acute in the first years of the program, this is particularly difficult as the start-up costs far exceed 10% of the cost of providing care.

### 5.1.3 Benefit Structure

PeachCare for Kids offers primarily the same benefits as the Medicaid program, with the exceptions of non-emergency transportation and targeted case management. The breadth of the benefits was well received by the focus group participants.

CAHPS survey data indicate that our enrollees are satisfied with access and quality of care that they receive from PeachCare for Kids. The CAHPS Survey

Highlights provide more information about satisfaction with and access to the benefits offered through PeachCare for Kids. (See Sections 4.4.3 and 4.5.2.)

5.1.4 Cost-Sharing (such as premiums, co-payments, compliance with 5% cap)

Premiums are required for children over the age of six: $7.50 per child per month, $15 per month for two or more children. Children ages 5 and younger are covered without cost to the family. There are no co-payments or deductibles. Since the program's inception through September 1999, just 141 families disenrolled because of the cost of the monthly premium.

The cost-sharing requirements were designed to reduce barriers to accessing care that may be created when families must meet a deductible or incur out-of-pocket costs upon receiving care. When asked about different cost sharing options, the focus group participants consistently were in favor of paying premiums rather than co-payments, citing the convenience of being able to access services as needed without worrying about having money in their pocket that day.

5.1.5 Delivery System

Using the Medicaid delivery system for PeachCare for Kids has many advantages. As many of the children have previous experience with Medicaid, they are able to maintain relationships with their former primary care physicians and are familiar with the benefits and procedures for accessing care. There are also benefits to providers as they are already enrolled and are familiar with the Medicaid program.

The greatest challenge with the delivery system is not exclusive to PeachCare for Kids. A lack of dental providers who participate in PeachCare for Kids and Medicaid makes it difficult for enrollees to access these services. The Governor has proposed an increase in dental reimbursement to create incentives for provider participation. If adopted, the increased rates would become effective July 1, 2000. CAHPS survey data indicate that our enrollees are satisfied with the PeachCare delivery system. The CAHPS Survey Highlights provide more information on participant satisfaction with the PeachCare for Kids delivery system. (See Sections 4.4.3 and 4.5.2.)

5.1.6 Evaluation and Monitoring (including data reporting)

PeachCare for Kids has benefited from having a relationship with health policy researchers at the Georgia Health Policy Center of Georgia State University. It has been helpful for ongoing monitoring of the program to get feedback from new enrollees, disenrollees, and people who have used health services. The Health Policy Center has conducted surveys of each of these groups. They have also arranged focus groups of non-enrollees; and in the summers of 2000 and 2001, they will look at patterns of utilization to assess access, quality, and quality

improvement. Funding for ongoing monitoring and evaluation comes from Medicaid funds because CHIP funding for evaluation is inadequate due to the multiple demands on the ten percent cap.

We have also benefited from regular reports from our TPA. The reporting requirements were built into our contract with DHACS, which we believe is a model contract.

5.1.7 Coordination with Other Programs (especially private insurance and crowd out)

As part of the Department of Community Health, PeachCare for Kids has a high level of coordination with Medicaid. As the Department develops its vision for improving health care access and quality within the state, PeachCare for Kids is part of that vision. The commonality of staff fosters an environment where both programs are working towards the same goal. As potential improvements in systems capabilities and administrative procedures are developed, the benefits to both programs are considered.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

The Governor has proposed increasing Medicaid eligibility for pregnant women and newborns and PeachCare for Kids eligibility up to 235% FPL. If approved, an estimated 22,000 uninsured children will gain access to affordable health care through PeachCare for Kids.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Provide states with more flexibility to create and maintain outreach efforts without the limitations of a 10% cap on administrative costs, including outreach expenditures. With the goal of improving the health status of Georgia's children, outreach is needed on many levels. Families need to be made aware of the program and, once enrolled, educated to the benefits of the program and encouraged to access preventive care. The high cost of start-up, before health care costs can be incurred, means that many of the outreach and administrative costs required for a successful program are the sole responsibility of the state.

Allow state employees to participate in the S-CHIP program. The limitation on their participation in PeachCare for Kids creates an inequality among families with similar incomes, based solely on the employer. Parents who have already elected to purchase the state health benefit coverage would not be allowed to drop the current coverage outside of an open enrollment period. Furthermore, families choosing to drop that coverage would have to wait three months before enrolling PeachCare for Kids. With these crowd-out provisions in place, the only families

that are being adversely affected by this policy are those who do not currently have state health benefits, simply due to their inability to afford the premiums, co-payments and deductibles.